Multiple Procedure Payment Policy

Policy Overview

This policy documents Neighborhood Health Plan of Rhode Island's (Neighborhood's) coverage and payment requirements for multiple procedure reductions.

Multiple procedures are separate procedures performed by a single physician or physicians in the same group practice on the same patient at the same operative session or on the same day for which separate payment may be allowed.

Scope

This policy applies to**:**

☒**Medicaid** *excluding Extended Family Planning (EFP)*
☒**Commercial**
☒**Dual CONNECT (Coordination only D-SNP)**
☒**INEGRITY for Duals (Fully Integrated D-SNP)**

Prerequisites

It is the provider's responsibility to verify eligibility, coverage and authorization criteria prior to rendering services.

For more information please refer to:

- Neighborhood's plan specific Prior Authorization Reference page.
- Neighborhood's Clinical Medical Policies.

Please contact Provider Services at 1-800-963-1001 for additional details.

Reimbursement Guidelines

Multiple Surgical Reductions (MSR) and National Correct Coding Initiative (NCCI) guidelines apply to multiple procedures performed by the same physician or physician group, on the same day.
Apply modifiers that affect payment in the first modifier field, followed by informational modifiers.

Modifier 50 (bilateral procedures)-

- Report bilateral procedures on a single claim line with a unit of 1 and modifier -50.
- Do not report bilateral procedures with modifier RT and LT on 2 separate lines.
- CPT or HCPCS codes with 'bilateral' or 'unilateral or bilateral' written in the description should not be billed with modifier -50.

Modifier 51 (multiple procedures)-

- Report procedures with the highest allowed amount without the multiple procedures modifier -51.
- Report additional procedures performed by the surgeon on the same day with modifier-51.

Medicaid and **Commercial** Lines of Business

Ambulatory Surgery Centers (ASC's) Services:

Neighborhood reimburses multiple procedure claims as follows:

- The procedure with the highest allowed amount at 100% of the contracted rate
- The procedures with the second, third, fourth, and fifth highest allowed amounts at 50% of the contracted rate
- The sixth and any additional procedures are considered global and will not be separately reimbursed.

Non-ASC Services:

Neighborhood reimburses multiple procedure claims as follows:

- The procedure with the highest allowed amount at 100% of the contracted rate
- The procedure with the second highest allowed amount at 50% of the contracted rate
- The procedures with the third, fourth, and fifth highest allowed amounts at 25% of the contracted rate
- The sixth and any additional procedures are considered global and will not be separately reimbursed

INTERGRITY for Duals and Dual CONNECT

Neighborhood follows all applicable Medicare multiple procedure reduction rules. Examples include but are not limited to:

Ambulatory Surgery Centers (ASC's)

Neighborhood reimburses multiple procedure claims as follows:

- The highest paying surgical procedure at 100%
- For all the other ASC covered surgical procedures subject to the multiple procedure discount at 50% of the applicable payment rate(s)

Non-ASC Services:

Neighborhood reimburses multiple procedure claims as follows:

- 100% of the fee schedule amount for the highest valued procedure
- 50% of the fee schedule amount for all other procedures

Outpatient Rehabilitation Services:

Neighborhood reimburses codes contained on the list of "always therapy[1]" services as follows:

- Full payment is made for the unit or procedure with the highest practice expense (PE) payment
- For subsequent units and procedures furnished to the same patient on the same day full payment is made for work and malpractice and 50% payment is made for the PE

Professional Component of Certain Diagnostic Imaging Procedures:

Neighborhood reimburses codes with a multiple procedure value of 4 as follows:

- Full payment is made for the PC of the highest priced procedure
- For each additional procedure when furnished by the same physician or physician group, the PC payment is reduced by 5%

Technical Component of Diagnostic Cardiovascular Services:

Neighborhood reimburses codes with a multiple procedure value of 6 as follows:

- 75% of the TC portion (codes with an indicator of '1') will be allowed
- If the PC/TC indicator is '3' (TC only codes), 75% of the full fee schedule for that code will be allowed

All Lines of Business

Endoscopy Families and Payment Rules

When multiple related endoscopic procedures from the same procedural family are performed on the same day by the same physician or other qualified healthcare professional, the lower-ranked endoscopy codes will be adjusted according to the Endoscopic Families and Payment Rule. This adjustment reduces the allowed amount based on the value of the endoscopic base code, which itself is not reimbursed. Endoscopies subject to reduction can be identified with an indicator of 3 on the Multiple Procedure field on the CMS Physician Fee Schedule.

If multiple endoscopies from the same family are performed alongside other procedures subject to multiple procedure reductions, they will be ranked accordingly and may be subject to both endoscopic and multiple procedure reductions.

In cases where two or more endoscopic procedures are performed on the same day but belong to different procedural families, the multiple procedure reduction will apply to the endoscopic codes with the lower relative value units (RVUs).

[1] Medicare Claims Processing Manual

Claim Submission

Billable services are subject to contractual agreements, when applicable. Providers are required to submit complete claims for payment within contractually determined timely filing guidelines.

Coding must meet standards defined by the American Medical Association's Current Procedural Terminology Editorial Panel's (CPT®) codebook, the International Statistical Classification of Diseases and Related Health Problems, 10th revision, Clinical Modification (ICD-10-CM), and the Healthcare Common Procedure Coding System (HCPCS) Level II.

Member Responsibility

Commercial plans include cost sharing provisions for coinsurance, copays, and deductibles. Members may have out of pocket expenses based on individual plan selection and utilization. Please review cost sharing obligations or contact Member Services prior to finalizing member charges.

For Dual CONNECT (Coordination only D-SNP plan), providers must submit claims to Neighborhood and any remaining copays/coinsurance amounts and Medicaid covered benefits to EOHHS for reimbursement.

Disclaimer

This payment policy is informational only and is not intended to address every situation related to reimbursement for healthcare services; therefore, it is not a guarantee of reimbursement.

Claim payments are subject to the following, which include but are not limited to: Neighborhood Health Plan of Rhode Island benefit coverage, member eligibility, claims payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements, and state and federal regulations. References to CPT or other sources are for definitional purposes only.

Neighborhood processes Dual CONNECT in accordance with CMS Medicare guidelines. Neighborhood processes INTEGRITY for Duals in accordance with CMS Medicare and Rhode Island Executive Office of Health and Human Services (RI EOHHS) guidelines. Refer to CMS Medicare guidance and RI EOHHS Provider Manuals & Guidelines for rules and claims processing policies.

This policy may not be implemented exactly the same way on the different electronic claims processing systems used by Neighborhood due to programming or other constraints; however, Neighborhood strives to minimize these variations.

The information in this policy is accurate and current as of the date of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to update this payment policy at any time. All services billed to Neighborhood for reimbursement are subject to audit.

Document History

Date	Action
09/01/2026	Added Endoscopy Families and Payment Rules section effective 9/1/26 for Medicaid and Commercial, effective 1/1/26 for INTEGRITY for Duals and Dual CONNECT.
01/01/2026	Updated policy template to include new lines of business. Updated Member Responsibility and Disclaimer language. Included reimbursement guidelines for INTEGRITY for Duals and Dual CONNECT.
09/18/2024	Annual Policy Review Date. No content changes.
08/01/2023	Annual Policy Review Date. Updated modifier 50/51 language
10/01/2022	Annual Policy Review Date. Removed distinct services modifier language; refer to modifier policy
03/11/2022	Updated language for Non ASC Services.
09/29/2021	Annual Policy Review Date. No Content Changes.
11/02/2020	Policy Effective Date
08/28/2020	Policy Review Date
02/10/2020	Document Created